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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 14
6010.53-M
APRIL 17, 2003

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL

The TRICARE Management Activity has authorized the following addition(s)/ revision(s) to the 6010.53-M, issued March 2002.

CHANGE TITLE: CONSOLIDATED PRIORITY MANUALS CHANGE

PAGE CHANGE(S): See page 2.

SUMMARY OF ADDITIONS/REVISIONS: The attached package is a consolidation of six separate change orders previously coordinated with the Managed Care Support Contractors (MCSCs) as part of the bilateral contracting process. They include the: 1) High Priority 7 Change Package; 2) Consolidated Policy Manual Update; 3) Consolidated TRICARE Reimbursement Manual Update; 4) Cost Operations Manual Update; 5) No-Cost Operations Manual Update; and 6) ADP Manual Update. These consolidated manual changes will be issued as a single unilateral change order.

IMPLEMENTATION DATE: The Implementation Date is August 1, 2003.

This change is made in conjunction with May 1999 ADP Manual, Change No. 35; Mar 2001 MCSC Operations Manual, Change No. 24; and Mar 2002 Policy Manual, Change No. 6.

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ATTACHMENT(S): 55 PAGE(S)
DISTRIBUTION: 6010.53-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1 (**Network Provider Reimbursement**) clarifies all claim payments for individual services (whether in-system or out-of-system) may not exceed the maximum payment methodology set forth by Federal law.

2. Section 14 (**Ambulance Services**) Under current policy, ambulance prevailing charges can only be used if the need for ALS services can be specifically justified on the claims (i.e., the required capabilities of the ALS which are not available in a Basic Life Support (BLS)). If justification is not submitted, development is not required and payment is based on the profile for basic ambulance service. However, there are situations where local ordinances or regulations mandate ALS as the minimum standard of patient transportation within a municipality and/or geographical area. There are also localities in which only ALS ambulance vehicles are available. In these situations, the type of vehicle used, rather than the level of service, is normally the primary factor in determining payments. The new reimbursement guidelines will ensure that TRICARE beneficiaries have access to the level of emergency care required for responding to 911 service calls; i.e., will allow payment at the ALS level if local ordinances or regulations mandated ALS as the minimum standard of patient transport for 911 service calls. The procedural guidelines will be consistent with the level of services and amounts pursuant to state law. It will also be consistent with the payment provisions for ambulance transfers currently in effect under Medicare. In addition, extends coverage of ambulance transfers ordered by military personnel.

3. Section 19 (**Skilled Nursing Services**) corrects typos.

4. Section 25 (**Hospital Reimbursement - Outpatient Services**) requires outpatient hospital services to be paid according to TMA's existing allowable charge methodologies. Clarifies payment for outpatient facility services.

5. Section 29 (**Reduction Of Payment For Noncompliance With Utilization Review Requirements**) eliminates the reduction in payment for failure to obtain preauthorization or preadmission authorization for those beneficiaries with other primary health insurance.

6. Section 30 (**Reimbursement Of Emergency Inpatient Admissions To Unauthorized Facilities**) allows for the payment of an emergency admission to an unauthorized institutional provider for medically necessary and appropriate care up to the point of discharge or until medically appropriate and legally authorized transfer can be initiated. Billed charges will be paid for all medically necessary care. Payment may be made directly to an unauthorized provider as long as the beneficiary's signature is on file authorizing payment to the provider and assuring patient confidentiality.

SUMMARY OF CHANGES (Continued)

CHAPTER 2

7. Section 1 (**Cost-Shares And Deductibles**) clarifies cost-sharing of procedures performed in ambulatory surgical centers that are not currently listed in Chapter 13, Addendum 1, Section 1 though 15. The unlisted procedures will be cost-shared on an outpatient basis on or after January 28, 2000.

8. Section 2 (**Catastrophic Loss Protection**). Clarification added regarding the application of expenditures to enrollment year and fiscal year catastrophic cap for active duty service members that retire other than the first of the month and enroll as retirees in TRICARE Prime without a break in service.

CHAPTER 3

9. Section 1 (**Reimbursement Of Individual Health Care Professionals And Other Non-Institutional Health Care Providers**) deleted obsolete language related to comparison of billed charges with prevailing rates for services billed using the prevailing charge methodology.

10. Section 2 (**Hospital And Other Institutional Reimbursement**) clarifies required information. For paragraph IV., changes receiving office from Data Quality and Functional Proponency Aurora (DQ&FP) to Medical Benefits and Reimbursement (MR&RS) and added electronic mail as an acceptable format by which inpatient mental health, partial hospitalization and RTC rates may be submitted to TMA. Revised table, field 3, to require "Current Fiscal year plus the two previous Fiscal Year iterations" instead of separate field for each Fiscal Year/iteration. Revised table, field 8, to remove reference to the ADP Manual and include "Alpha Code" in place of reference. Revised table, field 9, to require an alpha numeric zip code. Revised table, field 10, to include clarification for Inpatient Low Volume Per Diem Rate.

CHAPTER 4

11. Section 1 (**Double Coverage**) adds language that indicates TRICARE is 1st payer for allowable IDEA Part C services and implements a policy decision approved by the TMA Deputy Executive Director on October 12, 2000. The change does not require any change in claims processing, but simply requires that TRICARE limitations on payments be applied in all double coverage situations in order to reduce beneficiaries' liability. Thus, a beneficiary will have no out-of-pocket liability even if TRICARE pays nothing on a claim because the primary payer pays a network provider more than the TRICARE negotiated rate.

SUMMARY OF CHANGES (Continued)

CHAPTER 5

12. Section 2 (**Allowable Charges-CHAMPUS Maximum Allowable CHARGES (CMAC)**) removes anesthesia and lab from the categories of care not subject to the national allowable charge system.

CHAPTER 6

13. Section 2 (**Hospital Reimbursement - TRICARE/CHAMPUS DRG-based Payment System (General Description Of System)**) clarifies paragraph C.2., applies to active duty family members and C.3., applies to active duty members.

14. Section 4 (**Hospital Reimbursement - TRICARE/CHAMPUS DRG-Based Payment System (Applicability Of The DRG System)**) adds pancreas transplant alone (PTA), pancreas after kidney (PTA) as covered under DRG effective 10/01/1999.

CHAPTER 7

15. Section 1 (**Hospital Reimbursement – TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System)**) updating mental health deflator factor for 2001 and 2002.

CHAPTER 9

16. Section 1 (**Ambulatory Surgical Center Reimbursement**) adds language to allow reimbursement of procedures performed in ambulatory surgical centers that are not currently listed in Chapter 13, Addendum 1, Section 1 though 15. The unlisted procedures will be cost-shared on an outpatient basis on or January 28, 2000.